Maryland Medical Care Data Base and Data Collection

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Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 25 MARYLAND HEALTH CARE COMMISSION

Chapter 06 Maryland Medical Care Data Base and Data Collection

Authority: Health-General Article, §§19-101, 19-103(c)(3), (4), (7), and (8), 19-109(a)(1), (6), and (7), 19-133, and 19-134, Annotated Code of Maryland

.01 Scope.

A. This chapter applies to payers whose total premiums collected in the State for health benefit plans exceed $1,000,000. With the exception of Medicare supplemental plans and certain dental and vision information, the applicability of this chapter to an individual payer is based on the information reported by the payer to the Maryland Health Care Commission (MHCC) on the MHCC Fiscal Year User Fee Assessment Surveys and required under Health-General Article, §19-111, Annotated Code of Maryland. Premiums collected in the State for Medicare supplemental, and dental and vision plans, shall be counted toward the $1,000,000 threshold. Third-party administrators and pharmacy benefit managers servicing standalone prescription benefits plans are expected to submit data, if requested by the Center Director, but are not subject to the penalties described in COMAR 10.25.12.

B. This chapter identifies the six types of health care data reports that payers shall submit to the Commission on a calendar year basis. These reports are the:

(1) Professional Services Data Report;

(2) Pharmacy Data Report;

(3) Provider Directory Report;

(4) Institutional Services Data Report;

(5) Medical Eligibility Data Report; and

(6) Pharmacy Eligibility Data Report.

C. All reports shall be submitted in accordance with this chapter. The Commission shall annually notify each payer in writing of the payer's reporting responsibilities under this chapter and will post current submission updates on the Commission's official web site.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Adjudicated" means paid, resolved, or settled.

(2) "Claim control number" means a payer's internal number used to track a claim.

(3) "Commission" means the Maryland Health Care Commission.

(4) "Crosswalk" means a list of all codes and their definitions in a separate file that maps to a specific data field.

(5) "Center Director" means the Center Director for Information Services and Analysis at the Maryland Health Care Commission.

(6) "Fee-for-service encounter" means a medical care visit in which a health care practitioner or office facility provided a health care service for which a claim was submitted to a payer for payment, and payment was made on a per service basis.

(7) "Health care practitioner" means a person who is licensed, certified, or otherwise authorized under Health Occupations Article, Annotated Code of Maryland, to provide health care services.

(8) "Health care service" means a health or medical care procedure or service rendered by a health care practitioner that:

(a) Provides testing, diagnosis, or treatment of human disease or dysfunction; or

(b) Dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of human disease or dysfunction.

(9) Line Item.

(a) "Line item" means a single entry on a bill associated with a health care service reimbursed by a payer.

(b) "Line item" contains information on the procedure performed, the rendering practitioner, service dates, practitioner charges, and payer reimbursement.

(10) "Medical Care Data Base" means the Maryland Medical Care Data Base.

(11) "MHCC Fiscal Year User Fee Assessment Survey" means the Commission’s fiscal year survey detailing premiums attributable to health benefit plans for determining applicability of the Medical Care Data Base requirements set forth in this chapter.

(12) "NCPDP number" means the unique 7-digit number assigned by the National Council for Prescription Drug Program.

(13) "NDC number" means the 11-digit National Drug Code number.

(14) “NPI number” means the 10-digit National Provider Identifier number assigned by the federal government to health care providers and used in all HIPAA transactions.

(15) "Office facility" means a freestanding facility providing:

(a) Ambulatory surgery;

(b) Radiologic or diagnostic imagery; or

(c) Laboratory services.

(16) "Payer" means a:

(a) Health insurer or nonprofit health service plan that holds a certificate of authority and provides health insurance policies or contracts in Maryland; and

(b) Health maintenance organization (HMO) that holds certificates of authority in Maryland.

(17) "Practitioner federal tax ID number" means the federal tax identification number of the practitioner/practice/supplier or office facility receiving reimbursement for the service provided.

(18) "Practitioner/supplier ID number" means the unique identification number used by the submitting payer to identify the particular practitioner or supplier.

(19) "Primary diagnosis" means the principal diagnosis for the health care service visit.

(20) "Specialty care capitated encounter" means a health care visit:

(a) In which a health care practitioner or office facility provides a service pursuant to an agreement with a payer for reimbursement on an aggregate fixed sum or per capita basis; and

(b) Which requires a referral or preauthorization from a primary care physician.

(21) "Supplier" means a person or entity, including a health care practitioner, that supplies medical goods or services.

.03 Designation of Payers to Submit Data Reports.

A. By December 31 of the prior year for which the data is to be submitted, the Executive Director or designee shall designate the payers that are required to submit data reports based on the payer's premium volume as defined in Regulation .01 of this chapter.

B. The Commission shall timely notify each designated payer of the data reporting requirements.

.04 Time for Submitting Data Reports.

A. On or before June 30 of each year, a designated payer shall submit to the Commission a complete set of the payer's previous calendar year's data as described in Regulations .06 —.11 of this chapter.

B. For each annual submission, a 16-month set of all claims is due. Claims that must be submitted are all claims adjudicated between January 1 of the previous calendar year through April 30 of the year the submission is due.

.05 Encryption.

A. Before data is submitted to the Commission, each payer shall encrypt patient identifiers using an encryption method provided by the MHCC such that each individual patient has only one encrypted identifier.

B. Before data is submitted to the Commission, each payer shall encrypt its internal subscriber contract numbers using an encryption method provided by the MHCC such that each contract has only one encrypted identifier.

C. Before data is submitted to the Commission, each payer shall encrypt its internal employer registration numbers using an encryption method provided by the MHCC such that each employer has only one encrypted identifier.

D. Each payer shall maintain the security and preserve the confidentiality of the encryption algorithms.

.06 Professional Services Data Report Submission.

A. Each payer shall submit a professional services data report that reports all fee-for-service encounters and specialty care capitated encounters provided by health care practitioners and office facilities. This report shall include all health care services provided to Maryland residents, including dental and vision services provided under a medical benefit plan, whether those services were provided:

(1) By a health care practitioner located in-State or out-of-State; or

(2) Under a health benefit plan or a Medicare Supplemental Plan.

B. Each payer shall submit pharmacy data in a separate professional services data file format as set forth in Regulation .07 of this chapter.

C. Each professional services data report shall contain the data elements in §D of this regulation.

D. Data Elements.

(1) Patient ID. The value shall be encrypted by the payer according to Regulation .05 of this chapter.

(2) Patient Year and Month of Birth.

(3) Patient Sex.

(4) Consumer Directed Health Plan.

(5) Patient Zip Code.

(6) Patient Covered by Other Insurance.

(7) Coverage Type.

(8) Delivery System Type.

(9) Claim-Related Condition.

(10) Practitioner Federal Tax ID.

(11) Participating Provider Flag.

(12) Type of Bill.

(13) Claim Control Number.

(14) Claim Paid Date.

(15) Number of Diagnosis Codes.

(16) Number of Line Items.

(17) Diagnosis Code 1.

(18) Diagnosis Code 2.

(19) Diagnosis Code 3.

(20) Diagnosis Code 4.

(21) Diagnosis Code 5.

(22) Diagnosis Code 6.

(23) Diagnosis Code 7.

(24) Diagnosis Code 8.

(25) Diagnosis Code 9.

(26) Diagnosis Code 10.

(27) Service from Date.

(28) Service thru Date.

(29) Filler (space fill).

(30) Place of Service.

(31) Service Location Zip Code.

(32) Service Unit Indicator.

(33) Units of Service.

(34) Procedure Code. If a payer uses a payer-specific code, other than CPT-4, HCPCS, or NDC, the payer shall provide a crosswalk that accompanies the professional services data report.

(35) Modifier I. If a submitting payer uses modifiers, the payer shall provide a crosswalk of their modifiers and their definitions that accompanies the professional services data report.

(36) Modifier II. If a submitting payer uses modifiers, the payer shall provide a crosswalk of their modifiers and their definitions that accompanies the professional services data report.

(37) Servicing Practitioner ID.

(38) Billed Charge.

(39) Allowed Amount.

(40) Reimbursment Amount.

(41) Date of Enrollment.

(42) Date of Disenrollment.

(43) Patient Deductible.

(44) Patient Coinsurance or Patient Co-payment.

(45) Other Patient Obligations.

(46) Plan Liability.

(47) National Provider Identifier (Servicing Practitioner).

.07 Pharmacy Data Report Submission.

A. Each payer shall submit a pharmacy data report for all prescription drug encounters. This report shall include all pharmacy services provided to Maryland residents whether the services were provided by a pharmacy located in-State or out-of-State.

B. Each pharmacy data report shall contain the data elements listed in §C of this regulation.

C. Data Elements.

(1) Patient ID. The value shall be encrypted by the payer as set forth in Regulation .05 of this chapter.

(2) Patient Sex.

(3) Patient Zip Code.

(4) Patient Date of Birth.

(5) Pharmacy NCPDP Number.

(6) Pharmacy Zip Code.

(7) Practitioner DEA #. This value shall be identical to element 11 in the provider directory report.

(8) NDC Number.

(9) Drug Compound.

(10) Drug Quantity.

(11) Drug Supply.

(12) Date Filled.

(13) Billed Charge.

(14) Reimbursement Amount.

(15) Prescription Claim Number.

(16) National Provider Identifier (Prescribing Practitioner).

(17) Patient Deductible.

(18) Patient Coinsurance or Patient Co-payment.

(19) Other Patient Obligations.

.08 Provider Directory Report Submission.

A. Each payer shall submit a provider directory report detailing all health care practitioners and suppliers who provided services to that payer's enrollees during the reporting period. This report shall contain information for all in-State Maryland practitioners/suppliers and all those out-of-State practitioners/suppliers serving Maryland residents.

B. Each provider directory report shall contain a crosswalk of every practitioner and supplier ID listed in the professional services data report and the pharmacy data report.

C. Each provider directory report shall contain the data elements listed in §D of this regulation.

D. Data Elements.

(1) Practitioner/Supplier ID.

(2) Practitioner/Supplier Federal Tax ID without embedded dashes.

(3) Practitioner/Supplier Last Name or Multi-practitioner Health Care Organization.

(4) Practitioner/Supplier First Name.

(5) Practitioner Middle Initial.

(6) Practitioner Name Suffix.

(7) Practitioner Credential.

(8) Practitioner/Supplier Specialty—1.

(9) Practitioner/Supplier Specialty—2.

(10) Practitioner/Supplier Specialty—3.

(11) Practitioner DEA #.

(12) Indicator for Multi-practitioner Health Care Organization.

(13) National Provider Identifier (Servicing Practitioner).

(14) Maryland Health Professional License Number.

.09 Institutional Services Data Report Submission

A. Each payer shall submit an institutional services data report that reports all institutional health care services provided to Maryland residents, whether those services were provided:

(1) By a health care facility located in-State or out-of-State; or

(2) Under a health benefit plan or a Medicare Supplemental Plan.

B. Each institutional services data report shall contain the data elements in §C of this regulation.

C. Data Elements.

(1) Patient ID. The value shall be encrypted by the payer according to Regulation .05 of this chapter.

(2) Patient Year and Month of Birth.

(3) Patient Sex.

(4) Patient Zip Code of Residence.

(5) Hospital/Facility Tax ID.

(6) Hospital/Facility National Provider Identifier Number.

(7) Claim Control Number.

(8) Record Type.

(9) Type of Admission.

(10) Source of Admission.

(11) Patient Disposition.

(12) Date of Admission or Start of Service.

(13) Date of Discharge or End of Service.

(14) Primary Diagnosis Code 1.

(15) Diagnosis Code 1 present at Admission 1.

(16) Diagnosis Code 2.

(17) Diagnosis Code 2 present at Admission 2.

(18) Diagnosis Code 3.

(19) Diagnosis Code 3 present at Admission 3.

(20) Diagnosis Code 4.

(21) Diagnosis Code 4 present at Admission 4.

(22) Diagnosis Code 5.

(23) Diagnosis Code 5 present at Admission 5.

(24) Diagnosis Code 6.

(25) Diagnosis Code 6 present at Admission.

(26) Diagnosis Code 7.

(27) Diagnosis Code 7 present at Admission 7.

(28) Diagnosis Code 8.

(29) Diagnosis Code 8 present at Admission 8.

(30) Diagnosis Code 9.

(31) Diagnosis Code 9 present at Admission 9.

(32) Diagnosis Code 10.

(33) Diagnosis Code 10 present at Admission 10.

(34) Attending Practitioner National Provider Identifier Number.

(35) Operating Practitioner National Provider Identifier Number.

(36) Participating Provider Flag.

(37) Billed Charge.

(38) Allowed Amount.

(39) Reimbursement Amount.

(40) Total Patient Deductible.

(41) Total Patient Coinsurance or Patient Co-payment.

(42) Total Other Patient Obligations.

(43) Coordination of Benefit Savings or Other Payer Payments.

(44) Type of Bill.

(45) Patient Covered by Other Insurance.

(46) Procedure Code Indicator.

(47) Principal Procedure Code 1.

(48) Procedure Code 1 Modifier I.

(49) Procedure Code 1 Modifier II.

(50) Other Procedure Code 2.

(51) Procedure Code 2 Modifier I.

(52) Procedure Code 2 Modifier II.

(53) Other Procedure Code 3.

(54) Procedure Code 3 Modifier I.

(55) Procedure Code 3 Modifier II.

(56) Other Procedure Code 4.

(57) Procedure Code 4 Modifier I.

(58) Procedure Code 4 Modifier II.

(59) Other Procedure Code 5.

(60) Procedure Code 5 Modifier I.

(61) Procedure Code 5 Modifier II.

(62) Other Procedure Code 6.

(63) Procedure Code 6 Modifier I.

(64) Procedure Code 6 Modifier II.

(65) Other Procedure Code 7.

(66) Procedure Code 7 Modifier I.

(67) Procedure Code 7 Modifier II.

(68) Other Procedure Code 8.

(69) Procedure Code 8 Modifier I.

(70) Procedure Code 8 Modifier II.

(71) Other Procedure Code 9.

(72) Procedure Code 9 Modifier I.

(73) Procedure Code 9 Modifier II.

(74) Other Procedure Code 10.

(75) Procedure Code 10 Modifier I.

(76) Procedure Code 10 Modifier II.

.10 Medical Eligibility Report Submission.

A. Each payer shall submit a medical eligibility data report that reports information on the characteristics of all enrollees covered for medical services under the plan.

B. Each medical eligibility data report shall contain the data elements in §C of this regulation.

C. Data Elements.

(1) Patient ID. The value shall be encrypted by payer according to Regulation .05 of this chapter.

(2) Patient Year and Month of Birth.

(3) Patient Sex.

(4) Patient Zip Code of Residence.

(5) Patient County of Residence.

(6) Patient Basic Race Reported.

(7) Patient Race.

(8) Patient Ethnicity Reported.

(9) Patient Ethnicity.

(10) Language Spoken at Home.

(11) Coverage Type.

(12) Delivery System Type.

(13) Policy Type.

(14) Plan Number.

(15) Contract Number. The value shall be encrypted by the payer according to Regulation .05 of this chapter.

(16) Employer Number. The value shall be encrypted by the payer according to Regulation .05 of this chapter.

(17) Scope of Benefits.

(18) Plan Liability.

(19) Consumer Directed Health Plan.

(20) Date of Enrollment.

(21) Date of Disenrollment.

(22) Relationship to Policyholder.

(23) Patient Covered by Other Insurance.

.11 Pharmacy Eligibility Report Submission.

A. Each payer shall submit a pharmacy eligibility data report that reports information on the characteristics of all enrollees covered for pharmacy services under the plan.

B. Each pharmacy eligibility data report shall contain the data elements in §C of this regulation.

C. Data Elements.

(1) Patient ID. The value shall be encrypted by payer according to Regulation .05 of this chapter.

(2) Patient Year and Month of Birth.

(3) Patient Sex.

(4) Patient Zip Code of Residence.

(5) Patient County of Residence.

(6) Patient Basic Race Reported.

(7) Patient Race.

(8) Patient Ethnicity Reported.

(9) Patient Ethnicity.

(10) Language Spoken at Home.

(11) Coverage Type.

(12) Delivery System Type.

(13) Policy Type.

(14) Plan Number.

(15) Contract Number. The value shall be encrypted by the payer according to Regulation .05.

(16) Employer Number. The value shall be encrypted by the payer according to Regulation .05 of this chapter.

(17) Scope of Benefits.

(18) Plan Liability.

(19) Consumer Directed Health Plan.

(20) Date of Enrollment.

(21) Date of Disenrollment.

(22) Relationship to Policyholder.

(23) Patient Covered by Other Insurance.

.12 Report Submission Methods.

A. The Commission shall provide payers with technical specifications, encryption algorithms, layouts, and definitions necessary for filing the six reports required by Regulation .01B of this chapter.

B. The information under §A of this regulation will be provided to payers by April 1 for data due that year.

C. Payers will be timely notified of any changes to the requirements specified in §A of this regulation.

.13 Security Safeguards.

A. To protect the privacy and confidentiality of the data that payers submit to the Medical Care Data Base, safeguards developed in accordance with State agency data systems security practices shall be used.

B. Access to the Maryland Medical Care Data Base is limited to authorized personnel only.

C. The Center Director shall:

(1) Designate in writing each individual authorized to have access to the Medical Care Data Base; and

(2) Establish the scope of access for each authorized individual.

D. Each authorized individual shall sign a confidentiality security agreement as specified by the Commission.

.14 Waiver or Exception Requests.

A. A payer may submit a written request for waiver of the reporting requirements for that year's data report.

B. A payer may submit a written exception request for format modification of the file layout of the submission method for that year's data report.

C. The Center Director shall grant requests only upon a payer showing extraordinary cause.

D. Waiver or Exception Request Requirements.

(1) In order to be considered for a waiver or format modification exception request, the payer shall comply with this section.

(2) All waivers or format modification exception requests shall be in writing to the Center Director by April 30 for data due that year.

(3) Full Waiver Request. The written request shall explain the reason or reasons for the waiver application. If premium volume for health benefit plans in Maryland is in question, a statement of premium volume form shall accompany the waiver application.

(4) Format Modification Request. The written request shall explain the reason or reasons for the format exceptions and describe in detail the payer's proposed layout or submission method, or both.

E. A payer may file a written appeal for the review of a denial of a full waiver or format modification request.

F. The Commission shall review the decision of the Center Director. The Commission may affirm, reverse, or modify the decision of the Center Director after providing the payer with an opportunity to present its position to the Commission.

.15 Extension of Time.

A. A payer may request an extension of time for up to 60 days after the due date of June 30.

B. The payer shall:

(1) Submit a written request to the Center Director of the Commission by May 30 for data due that year;

(2) Explain the reasons for the extension request; and

(3) Propose a reasonable submission date for the Commission to receive the data report.

C. The Center Director shall grant requests only upon a payer showing extraordinary cause.

D. A payer may file a written petition for review of a denial of an extension of time request.

E. The Commission shall review the decision of the Center Director. The Commission may affirm, reverse, or modify the decision of the Center Director after providing the payer with an opportunity to present its position to the Commission.

.16 Failure to File Data Reports.

A payer that does not timely file a data report may be subject to penalties as described in COMAR 10.25.12.

.17 Summaries and Compilations.

The Commission shall develop public-use data, summaries, and compilations for public disclosure, pursuant to Health-General Article, §§19-103(c)(3), 19-109(a)(6), and 19-134, Annotated Code of Maryland, in compliance with all applicable federal and state laws and regulations.

.18 Disclosure of Data for Research Use

All disclosures of data that qualify as "directly or indirectly identifiable health information", shall be subject to review by the Institutional Review Board as described in COMAR 10.25.11.